$25,000 or 5 percent of the HMO's total operating expenses, whichever is less.

(d) *Requirements for combined financial statements.* (1) The combined financial statements required by paragraph (b)(3) of this section must display in separate columns the financial information for the HMO and each of these parties in interest.

(2) Inter-entity transactions must be eliminated in the consolidated column.

(3) These statements must have been examined by an independent auditor in accordance with generally accepted accounting principles, and must include appropriate opinions and notes.

(4) Upon written request from an HMO showing good cause, HCFA may waive the requirement that its combined financial statement include the financial information required in this paragraph (d) with respect to a particular entity.

(e) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an HMO in its offerings, the HMO must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular HMO) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The HMO must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term ''administrator'' is defined in ERISA.

Subpart D—Application for Federal Qualification

§ 417.140 Scope.

This subpart sets forth—

(a) The requirements for—

(1) Entities that seek qualification as HMOs under title XIII of the PHS Act; and

(2) HMOs that seek—

(i) Qualification for their regional components; or

(ii) Expansion of their service areas;

(b) The procedures that HCFA follows to make determinations; and

(c) Other related provisions, including application fees.

[59 FR 49836, Sept. 30, 1994]

§ 417.141 Definitions.

As used in this subpart—

Operational qualified HMO means an HMO that HCFA has determined provides basic and supplemental health services to all of its enrollees in accordance with subpart B of this part and §§ 417.168 and 417.169, and is organized and operated in accordance with subpart C of this part and §§ 417.168 and 417.169.

Preoperational qualified HMO means an entity that HCFA has determined will, when it becomes operational, be a qualified HMO.

Transitionally qualified HMO means an entity that operates a prepaid health care delivery system and that HCFA has determined meets the requirements of § 417.142(b). A transitionally qualified HMO is considered a ''qualified HMO'' for the purpose of compliance by an employer with the requirements of section 1310 of the PHS Act and subpart E of this part. Under these requirements, the employer must include the HMO in its health benefits plan so long as the HMO's qualification has not been revoked under section 1312(b) of the PHS Act and § 417.163(d).

[58 FR 38070, July 15, 1993]

§ 417.142 Requirements for qualification.

(a) *General rules.* (1) An entity seeking qualification as an HMO must meet the requirements and provide the assurances specified in paragraphs (b) through (f) of this section, as appropriate.

(2) HCFA determines whether the entity is an HMO on the basis of the entity's application and any additional information and investigation (including site visits) that HCFA may require.

(3) HCFA may determine that an entity is any of the following:

(i) An operational qualified HMO.

(ii) A preoperational qualified HMO.

(iii) A transitional qualified HMO.

(b) *Operational qualified HMO.* HCFA determines that an entity is an operational qualified HMO if—

(1) HCFA finds that the entity meets the requirements of subparts B and C of this part.